

HealthX Call-for-Innovation

Redefining Health Coaching and Patient Education

Clarification and Responses (22 September 2026)

Q1. Call-for-Innovation Process: Participation, Evaluation and Commercial Model

(a) Who may participate in the CFI, and what consortium, partnership, local presence and delivery team arrangements are acceptable?

Response: The CFI is open to both local and overseas companies and startups. Respondents may submit proposals independently or through partnerships, consortiums or other collaboration arrangements where appropriate. Where multiple parties are involved, proposals should clearly describe the roles and responsibilities of participating organisations and demonstrate the collective capability and expertise required to support the proposed solution.

(b) How will submissions be evaluated and shortlisted, and what should respondents prepare for during Pitch Day, demonstrations and subsequent assessment activities?

Response: Proposals submitted for the CFI will be screened and reviewed based on the completeness of the proposal with reference to the scope, general requirements and intended outcomes outlined in the challenge statement. Companies of shortlisted proposals will then be informed to participate in the pitch session where evaluation criteria and expectations of the pitch will then be shared with shortlisted companies. Following the pitch day, selected industry company will then be informed for further discussions with the project sponsor on the co-development of POC.

(c) What funding, commercial, contracting and procurement arrangements are envisaged for the pilot, and what is the anticipated pathway from proof-of-concept to wider deployment if outcomes are achieved?

Response: The CFI is open to different funding and commercial models, including pilot-based, service-based, outcome-based and bundled approaches. Respondents should propose a model that is appropriate for the scope, risks and intended outcomes of their solution.

Innovation funding may be available to support the co-development of the proof-of-concept (PoC). The level of funding, if any, will be assessed on a case-by-case basis after the PoC scope and cost have been agreed. As this is expected to be a collaborative development effort, contributions from both the project sponsor and the selected industry partner may be required.

After awarding the selected partner, the CFI is intended to initiate an Outcome-Based Spiral Contracting approach. If the PoC achieves the agreed outcomes and delivers sufficient value, the parties may explore progression to subsequent phases and wider deployment. These phases may be delivered iteratively through short sprints, with scope, outcomes and commercial arrangements reviewed at each stage. Successful completion of the PoC does not, in itself, guarantee a production contract or wider deployment.

The procurement, contracting, payment and delivery arrangements will be finalised with the selected partner and will be subjected to the applicable procurement processes, internal approvals and contractual terms.

Intellectual property, data ownership and commercialisation terms will be addressed during contracting in accordance with applicable policies and requirements. Respondents should clearly identify any background intellectual property, proposed ownership or licensing of newly developed intellectual property, third-party dependencies, data-use requirements and commercialisation assumptions in their proposals.

Q2. Solution Content and Accessibility

(a) What approved content sources, organisational materials, governance processes and content-safety controls should be used to support health coaching and patient education?

Response: As outlined in the CFI, all responses should be grounded in approved organisational materials and aligned with relevant clinical guidelines, policies and governance processes. Solutions should support content review, approval, update and retirement workflows and demonstrate how approved organisational materials are maintained and surfaced in a safe and consistent manner. Respondents should describe their approach to knowledge management, content safety, version control and multilingual content delivery, as well as how approved content is surfaced to residents in a safe, consistent and governed manner. For the purpose of POC, all patient education materials can be found here:

Health Library - Health Information and Resources in Singapore

(<https://www.nuhs.edu.sg/care-in-the-community/health-together/health-library>)

(b) What language, dialect, voice and accessibility capabilities are expected to support the diverse resident populations served by PHCC?

Response: The CFI highlights the importance of multilingual capabilities to improve accessibility and better serve a diverse resident population. Respondents are encouraged to describe the multilingual, accessibility and engagement capabilities supported by their solution, including text, voice or other engagement modalities where applicable. Solutions should demonstrate how they support inclusive engagement for residents with varying language preferences, communication needs and levels of digital readiness.

(c) What resident, coaching and clinical context will be available to the solution to support personalised coaching, progress tracking and continuity of engagement throughout the health coaching journey?

Response: For the CFI Proof of Concept (PoC), the solution will use only synthetic, non-identifiable health-coaching profiles that do not relate to real individuals. No live patient records or actual patient data will be shared with, entered into or processed by the solution.

NUHS will provide the agreed scenarios and specifications required to create or configure these profiles. Each profile should contain only the minimum information needed to test the approved coaching scenarios. This may include broad age bands, preferred language, generalised health-coaching needs, stage of change, fictional SMART goals, simulated barriers and non-identifying or banded clinical indicators. Profiles must not include direct identifiers, contact details, medical record numbers, exact dates of birth, addresses, free-text clinical notes, recordings, images or rare combinations of attributes that could enable an individual to be identified or singled out.

The avatar may maintain continuity within a synthetic test scenario by referring to fictional prior conversations, goals and progress. Any summaries provided to Health Coaches or evaluators should use a non-identifying profile code and contain only the information needed to assess coaching quality, safety, escalation and workflow suitability.

Any subsequent phase involving identifiable patient data, live clinical workflows or system integration will require a separate privacy, cybersecurity, clinical-governance and regulatory assessment, including confirmation of applicable PDPA obligations, consent or other lawful basis, data-processing arrangements, retention controls and incident-response requirements.

(d) What role should CHAMP and WhatsApp play in the proposed solution, and is the expectation to integrate within, alongside, or through existing patient engagement channels and workflows?

Response: CHAMP is an established NUHS patient engagement platform that supports population health and chronic disease management through WhatsApp-based workflows. Respondents may propose standalone, integrated, or hybrid approaches for the proof-of-concept. Deployment within CHAMP is not mandatory during the pilot phase.

Proposals should describe how the solution could support future integration with existing patient engagement ecosystems, including WhatsApp-based channels such as CHAMP.

Respondents may propose text, voice, avatar, or multimodal experiences. Where multiple modalities are supported, proposals should demonstrate how conversational context, patient experience, governance controls, and continuity of engagement will be maintained across channels.

Regardless of modality, solutions should support patient safety, governance, human oversight, escalation workflows, and integration with broader care delivery processes where relevant. The primary objective is to deliver accessible, personalised, engaging, and scalable health coaching and patient education experiences using the synthetic, non-identifiable profiles described in Section 3.

Q3. Solution Specifications and Requirements

(a) How should the solution support the resident health coaching journey, and what roles should remain with Health Coaches versus the digital solution?

Response: The proposed solution is intended to augment, rather than replace, existing health coaching services. As described in the CFI, digital capabilities should support goal setting, behavioural reinforcement, health education, follow-up engagement and progress monitoring while enabling Health Coaches to focus on residents with higher-touch or more complex needs. Respondents are encouraged

to describe how their proposed solution supports the intended health coaching journey, continuity of engagement and enables effective collaboration between digital capabilities and Health Coaches.

(b) Is a visual avatar required, or may respondents propose alternative interaction models such as text, voice or multimodal conversational experiences to achieve the intended outcomes?

Response: For the purpose of this CFI, the focus is on a human-like digital health coach or nurse. Respondents must propose avatar-based or multimodal approaches, to effectively support the health coaching and patient education objectives outlined in the CFI. The primary consideration is the ability to deliver engaging, accessible, personalised and scalable interactions that enhance resident engagement and continuity of care. No specific avatar design, appearance, voice or persona is mandated at this stage.

(c) How are residents expected to access the solution, and what are the expectations regarding deployment model, operational ownership, support arrangements and site infrastructure?

Response: The CFI seeks solutions that provide accessible and scalable health coaching and patient education experiences across appropriate engagement channels and platforms. As described in the CFI, solutions should support on-demand access through channels such as mobile, web and community-based devices where appropriate. Respondents are encouraged to describe their proposed deployment, operating, user access, and support models and how the solution can be delivered across the intended resident and care delivery environments. Specific implementation and operational arrangements will be considered during subsequent stages of discussions.

(d) What patient cohorts, conditions, pilot scale, implementation scope and outcome measures are envisaged, and how will pilot success be determined?

Response: The intended outcomes of the CFI are outlined in Section 6 and include access and reach, workforce augmentation, consistency and safety, resident engagement, operational scalability and population health intelligence. The CFI is centred on population health, preventive care and chronic disease management use cases. Respondents are encouraged to propose meaningful outcome measures, evaluation approaches and success metrics that demonstrate impact across these outcome domains. Pilot success will be determined by the selected industry company and business user based on agreed key performance indicators (KPIs) and scope discussed.

(e) Which NUHS, Synapxe and national healthcare systems are expected to be integrated, and what interoperability standards, interfaces, sandboxes and test environments will be available to support implementation?

Response: System integration is not expected during the CFI Proof of Concept (PoC). The PoC should demonstrate the solution's core capabilities, user experience, safety, governance and operational feasibility in an appropriately controlled test environment using only the synthetic, non-identifiable profiles described in Section 3.

Respondents should nevertheless demonstrate how their architecture can support future integration with healthcare ecosystem platforms, including the NUHS Next Generation Electronic Medical Record (NGEMR), based on Epic, and other relevant NUHS, Synapxe, or national healthcare systems and workflows. Proposals should describe their interoperability approach, including support for industry-adopted standards, secure APIs, modular integration patterns, event- or service-based architectures, identity management, and configurable data exchange mechanisms.

No specific APIs, interfaces, sandbox environments, or test tenancies are committed at this stage. Any future integration requirements, system access, connectivity arrangements, and non-production environments will be defined during subsequent phases, subject to solution architecture reviews, technical feasibility assessments, cybersecurity requirements, operational considerations, and the relevant approvals.

(f) What clinical governance, human oversight, regulatory, consent and escalation requirements should the solution support to ensure safe deployment and accountability?

Response: The CFI Proof of Concept (PoC) is intended to evaluate health coaching and patient education capabilities in a controlled environment using de-identified, structured health coaching profiles. The solution is not intended to provide autonomous clinical decision-making, diagnosis, treatment recommendations, or substitute professional clinical judgement.

A human-in-the-loop governance model will apply during the PoC. Respondents should demonstrate capabilities that support human oversight, including review workflows, intervention mechanisms, auditability, traceability of outputs, and monitoring of system behaviour.

Solutions should incorporate appropriate safety guardrails and escalation mechanisms to identify interactions that fall outside approved health coaching and patient education boundaries, including potential clinical risks, safeguarding concerns, urgent situations, low-confidence responses, or requests beyond the intended scope. Such cases should be escalated to designated human reviewers or established care pathways.

The detailed clinical governance framework, consent model, accountability arrangements, escalation workflows, and regulatory requirements applicable to any future production deployment will be determined with the relevant NUHS stakeholders and subject to the appropriate governance, privacy, cybersecurity, clinical safety, and regulatory approval processes.

(g) What are the expectations regarding hosting, security, certifications, data residency, approved AI platforms and the governance of patient and AI-generated data?

Response: The CFI is technology-agnostic and does not prescribe a specific hosting environment, cloud provider, AI platform, foundation model, deployment architecture, or certification framework. Respondents may propose their preferred technology approach, provided it can support the governance, safety, security, scalability, interoperability, and operational requirements outlined in the CFI.

Respondents should describe their approach to:

- Hosting and deployment architecture
- Data residency and management of synthetic POC data, operational data and AI-generated outputs
- Access control, authentication, encryption, audit logging and monitoring
- AI governance, safety guardrails and human oversight
- Data minimisation, retention and secure deletion
- Restrictions on secondary use, disclosure and model training
- System reliability, business continuity, vulnerability management and incident response
- Readiness to interoperate with future healthcare-ecosystem capabilities

Respondents should demonstrate how their solution can operate within a regulated healthcare environment and adapt to prevailing enterprise security, privacy, governance, and compliance requirements. Any future implementation involving patient data, system integration, or production deployment will be subject to applicable NUHS, Synapxe, and national cybersecurity, privacy, architecture, governance, procurement, and regulatory review processes.